Kentucky Health Cooperative Inc.: KY Health Cooperative Silver 94 (CSR A)

Coverage Period: Beginning on January 1, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at: www.mykyhc.org or by calling: 1-855-OUR-KYHC (687-5942).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network $**250** per person/**$750** per family Non-Network $**4,500** per person/$**13,200** per family	You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services you use. See the chart starting on page 2 to find out how much you pay for covered services after you have met the Deductible. *Copayments, other than prescription drug, DO NOT Apply toward the Deductible
Are there other deductibles for specific services?	**NO**	You do not have to meet a Deductible for Prescription Drug Benefits
Is there an out–of–pocket limit on my expenses?	**YES** Network providers **$750** per person/ **$2,250** per family Non-Network providers **$10,000** per person/ **$30,000** per family	The Out-of-Pocket Limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit can help you plan for health care expenses. *Copayments, other than prescription drug, DO Apply toward the Out-of-Pocket Limit
What is not included in the out–of–pocket limit?	Premiums, Balance-billed charges, Health care received but not covered by this plan and Penalties.	Though you may have paid expenses in these areas, they do not count toward the Out-of-Pocket Limit
Is there an overall annual limit on what the plan pays?	**NO**	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	**YES**	If you use our Network provider, this plan will pay some or all of the costs of covered services. Any non-Network provider charges, even if used by one of your Network providers, may not be paid by this plan
Do I need a referral to see a specialist?	**NO**	You can see the Specialist you choose without permission from this plan, though possible non-payment, by this plan, for services from a Non-Network provider applies.

Are there services this plan doesn't cover?	**YES**	There are services not covered by this plan. Please consult your policy or plan documents for the list of Excluded Services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 10% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	70% Coinsurance	
	Specialist visit	$25 copay/visit	70% Coinsurance	
	Other practitioner office visit-chiropractor	$10 copay/visit	70% Coinsurance after deductible	Chiropractor: 12 manipulation visits per benefit period.
	Preventive care/screening/immunization	$0	70% Coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance after deductible	70% Coinsurance after deductible	In-Network coinsurance varies based upon setting where test received.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance after deductible	70% Coinsurance after deductible	In-Network coinsurance varies based upon setting where test received.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.mykyhc.org**	Generic drugs	$5 before deductible	$5 before deductible	No out-of-network mail order
	Preferred brand drugs	$10 after deductible	$10 after deductible	No out-of-network mail order
	Non-preferred brand drugs	$25 after deductible	$25 after deductible	No out-of-network mail order
	Specialty drugs	20% Coinsurance after deductible	20% Coinsurance after deductible	No out-of-network mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance after deductible	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required
	Physician/surgeon fees	10% Coinsurance after deductible	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required
If you need immediate medical attention	Emergency room services	$25 Copayment/visit before deductible + 10% Coinsurance	$25 Copayment/visit before deductible + 10% Coinsurance	May be waived if admitted. Maximum Allowable Amount applies to Out-of-Network services.
	Emergency medical transportation	10% Coinsurance after deductible	70% Coinsurance after deductible	Waived if admitted and related to accident/injury
	Urgent care	$75 Copay/visit	70% Coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance after deductible	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required
	Physician/surgeon fee	10% Coinsurance after deductible	70% Coinsurance after deductible	In-Network coinsurance varies based upon setting where service received.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay/visit	70% Coinsurance after deductible	
	Mental/Behavioral health inpatient services	10% Coinsurance after deductible	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required
	Substance use disorder outpatient services	$10 copay/visit	70% Coinsurance after deductible	
	Substance use disorder inpatient services	10% Coinsurance after deductible	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required
If you are pregnant	Prenatal and postnatal care	10% Coinsurance after deductible	70% Coinsurance after deductible	In-Network coinsurance varies based upon setting where service received.
	Delivery and all inpatient services	10% Coinsurance after deductible	70% Coinsurance after deductible	In-Network coinsurance varies based upon setting where service received.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% Coinsurance after deductible	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required/100 visits per calendar year
	Rehabilitation services	$10 copay/visit	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required/ Limit of 20 visits on certain services (speech therapy, physical therapy etc.)
	Habilitation services	10% Coinsurance after deductible	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required/ Limit of 20 visits on certain services (speech therapy, physical therapy etc.)
	Skilled nursing care	10% Coinsurance after deductible	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required/90 days maximum combined in and out of network
	Durable medical equipment	10% Coinsurance after deductible	70% Coinsurance after deductible	Pre-authorization/Pre-certification may be required/Hearing Aid for those <18 is 1 per 36 month period
	Hospice service	0% after deductible	0% after deductible	Pre-authorization/Pre-certification may be required
If your child needs dental or eye care	Eye exam	$25 copay	70% Coinsurance after deductible	1 per calendar year
	Glasses	10% Coinsurance after deductible	70% Coinsurance after deductible	1 pair per calendar year + 1 replacement pair if medically necessary
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric Surgery for Morbid Obesity
- Cosmetic Surgery, unless to correct a functional impairment
- Long-Term Care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Private Duty Nursing

Your Rights to Continue Coverage: If you lose coverage under this plan, then, depending upon the circumstances, Federal and State of KY laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under this plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, please contact the plan at: 1-855-OUR-KYHC or your state department of insurance, Department of Labor Employee Benefits Security Administration at: 1-866-444-EBSA (3272) or the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:
Kentucky Health Cooperative at www.mykyhc.org or 1-855-OUR-KYHC or your state insurance department, or;
Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Insurance, P.O. Box 517, Frankfort, KY 40602-0517 PH: 502-564-3630 or 800-595-6053 or TTY: 800-648-6056

Department of Insurance, Consumer Protection Division, P.O. Box 517, Frankfort, KY 40602-0517, website: http://insurance.ky.gov,
Email: DOI.Ombudsman@ky.gov, PH: 877-587-7222

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,755
- **Patient pays** $785

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Co-pays	$15
Co-insurance	$520
Limits or exclusions	$0
Total	**$785**

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Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,965
- **Patient pays** $435

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Co-pays	$15
Co-insurance	$170
Limits or exclusions	$0
Total	**$435**

** **ASSUMING START OF PLAN YEAR SO DEDUCTIBLES APPLIED IN FULL**

** The information for these examples is incomplete since time and place of service are key to deductible application.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.